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Issue Papers

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Creating Seamless Transitions While Improving EOL Care Across All Settings

By

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PACT Categories: Continuum of Care and Research

Creating Seamless Transitions While Improving EOL Care Across All Settings

Issue/Problem

The Institute of Medicine in their most recent report (2003), *Describing Death in America: What We Need to Know,* note the need for better information that goes beyond demographics and health conditions to issues that include quality of life for patients and their families and continuity of care during the last year of life..."the experience of dying." Teno, et al. (2004) have identified five domains for measurement of quality, one of which is coordination of care across settings. The Rand Health Acove Project (2001), *Developing Quality of Care Indicators for the Vulnerable Elderly* published in 2004 its quality indicators for continuity and coordination of care in vulnerable adults, but as yet these have not been widely disseminated, nor used to evaluate the current state of care. However, a report published in 2003 by *Last Acts*, an initiative of the Robert Wood Johnson Foundation, indicates that South Carolina ranks among the worst states on previously identified indicators of quality EOL care (advance directive laws, number of deaths in the hospital vs at home, number of ICU days, hospitals reporting hospice/palliative care programs, referrals to hospice, and professionals certified in palliative care, among others).

Previous studies have documented one or more transitions in care settings the last six months, and even the last 30 days of life among the frail elderly (Cooney, et al., 2001, Tolle, et al., 2000, Craig, 2002, and Lewis, Cretin, and Kane, 1985). Numbers of transfers between care settings, in part a function of fragmented reimbursement systems and uncertainty about death, vary in these studies from one to six during the last 30 days of life alone.

Fiscal Impact

Studies by CMS and others document the fact that costs the last year of life are substantially higher than at any other time. In fact, 30% of Medicare expenditures are spent on the 5% of Medicare recipients that die each year (Barnato, et al. (2004). Literature also documents regional variations in end-of-life care patterns. Better quality outcomes are not correlated with greater use of hospital stays, use of intensive care and aggressive treatments, and use of more physician specialty visits (Wennberg, 2000, Hanson, Tolle, and Martin, 2002). The Southeast, and specifically South Carolina, is among those regions of the US that rely more heavily on high cost hospital and other aggressive medical services. Strategies that address both provider patterns of care as well as coordination, communication, and continuity for vulnerable frail seniors very probably would have significant cost avoidance implications.

Barriers

Fins, et al. (2003) identify significant financial and regulatory disincentives, as well as non-financial barriers to the delivery of seamless end-of-life care. Among the non-financial barriers identified are: 1) conflicting goals among hospitals, nursing facilities, and hospice, 2) portability of patient data across care settings, 3) the absence of coordination across venues of care, and 4) interdisciplinary communication within a single setting and across settings. A fifth non-financial barrier underlying failures to coordinate and communicate across venues may, in fact, be a lack of role clarity and clear specification and assignment of responsibilities for 'discharge planning' and arrangements inherent in transfer processes. Wenger and Rosenfeld (2001) note that some measures of quality of end-of-life care have been developed, but most have not focused on the processes of care.

A pilot study (Craig & Dereng, 2004) conducted in upstate SC involving 60 randomly selected transfers of those 65 and older in 2003 identified the sources of transfers into hospice by referral source, and identified barriers to seamless transitions. The mean age of patients transferring was 82 years old, and the age group 85 years or older comprised 43% of the sample.

As a whole, these patients were quite ill at the time of the transfer with 44% having five or more sets of symptoms. Approximately 35% of the transfers originated from the hospital, another 12% from home health, 7% from nursing homes, and 47% from private physician offices. Greater than 60 percent of the patients did not have medical information accompanying them at the time of transfer, 52% had no advance directive to guide care, 45% had problems with durable medical equipment at the time of transfer, and another 40% had problems with prescriptions. Thirty-two percent of the sample had problems with both DME and medications.

Previous Approaches/Solutions

Recognizing the disruptions to continuity that transfers cause, a number of strategies have been investigated, recommended, and tried on limited populations. The most promulgated approach has been advance directives, particularly living wills, as a way of communicating preferences for type and amount of treatment preferred and coordinating care across health care venues (Wenger and Rosenfeld, 2001). However, this approach has been found to have limited utility for a variety of reasons. It is unlikely that advance directives will be either widely used by seniors of all socio-demographic population segments, or widely relied upon by multiple professionals to direct care across settings given different state laws that govern legal standing of these documents, and conflicting state regulations governing licensure, certification, or accreditation of different venues of care.

Other approaches that have emerged include: case managers supplied by managed care plans and/or organizations, care plans such as Oregon's *Physician Orders for Life-Sustaining Treatment (POLST)* that accompany patients across settings, communication and advocacy classes for caregivers, and with the diffusion of technology in health care, innovations that enhance the transfer of pertinent patient medical record information at the point of discharge from acute care. The Medicare Prescription Drug and Modernization Act of 2003, signed into legislation December 8, 2003, will allow Medicare to cover the costs of coordinating care for patients with multiple and severe chronic conditions. Of particular relevance to hospice providers is the new benefit which covers the cost of an educational consult by a hospice physician to terminally ill patients in settings other than hospice to perform pain assessments as well as counseling on care options and advance care planning, and regulation that allows nurse practitioners to continue treating their patients who enter hospice (Koppelman, 2004).

Whether either or both of these benefits improves coordination and continuity across venues remains to be evaluated. It is clear, however, that patients and their caregivers want one person coordinating their care (this ranks 13th of 74 items among the terminally ill and 16 of 77 among their caregivers), appropriate timing of referral and transfer (families who felt their loved one was referred 'at the right' time are significantly more satisfied), and more public education about financing and alternatives at the end of life (up to 90% of the public in one survey did not know that care in the home was 100% covered by the Medicare hospice benefit regardless of diagnosis).

Recommendations

It does not appear from a review of the literature that sufficient investigation has occurred relative to the numbers and nature of transfer processes, and the variables that influence the success or failure of those processes from the perspective of different stakeholders that include at least patients, their families, and multidisciplinary providers. It is proposed that more research be funded and conducted to 1) Determine the current state of continuity and coordination, and 2) Explore alternative strategies for improving the processes of transfer between settings. An initiative is currently in process, the SC Upstate EOL Educational Collaborative, partially funded by SC Alliance 2020, to educate providers across settings and set the stage for more research.

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Issue: Mental health and older adults

An area of health care largely overlooked at the national and state levels is the mental health status of persons developing into their later years, a time of life traditionally associated with an increased need for health care services. Although there are, no doubt, interactions of mental health status and physical health problems in aging individuals (Cohen, 1990), mental health problems in late life should not be considered solely as a consequence of aging.

Mental illness in older adults is defined to include dementia-causing conditions and psychiatric disorders and currently affects between 22-30% of the over-65 adult population (Gatz & Smyer, 1992). As the older adult population continues to grow as a percentage of the total population these measures are expected to increase by an additional 10% through 2030, resulting in a total of 23 million older adults diagnosable with a mental illness (Jeste, et al., 1999).

It is clear that many older adults in need of mental health services do no receive the care they need. The South Carolina Alzheimer's Disease Registry estimates that 73% of the 56, 974 persons with Alzheimer's in the state are currently receiving no treatment. South Carolina community mental health centers have not been able to serve more than a small percent of older persons in need of care (5% in FY97-98). The South Carolina Department of Mental Health Inpatient Services has designated just over half of its 2000 beds for older adults. The state currently maintains a waiting list of 3,600 for its community-based waivers program providing home-based support services. The total number of cases of Alzheimer's and related illnesses in the United States is expected to grow over the next three decades and reach an estimated 14-15 million as the baby-boom generation passes through the later years of life.

Dementia: Approximately 15% of older adults will experience the memory loss, confusion and disorientation of dementia-causing illnesses (Ritchie & Kildea, 1995). Alzheimer's disease currently accounts for over 60% of the total (American Psychiatric Association, 1994). Three to four million individuals in the United States suffer from Alzheimer's, with 300,000 new cases diagnosed each year, for a total health-care, one-year cost of approximately $100 billion. Additional costs for American businesses from the loss of work-related productivity of caregivers who make life adjustments to provide family support is estimated at $33 billion per year.

Of primary importance as additional causes of dementia are Parkinson's disease, Huntington's disease, Creutzfeldt-Jakob disease, and, most significantly for the total, stroke and complications of high blood pressure.

Depression: Chief among the other mental illnesses affecting older adults is depression. Depending on how the study samples are defined, from 5-20% of adults 65 and over living in the community experience depressive symptoms. The difficulty of distinguishing dementia from depression highlights a critical need for accurate

diagnoses since even severe depression is often reversible with appropriate treatment. Depression estimates run as high as 37% for residents in primary care settings.

Costs associated with depression are estimated at $43 billion per year in the United States. This total, however, does not include costs associated with reductions in quality of life due to pain and suffering and healthcare costs of excess disability.

Suicide: The feelings of helplessness and worthlessness of depression are often accompanied by suicidal ideation and suicide attempts. Older adults are at greatest risk for suicide as compared to all other age groups. Approximately 5,390 older adults in the United States succeed in committing suicide each year, accounting for 20% of the total number of suicides nationwide (Centers for Disease Control, 2005).

Anxiety: Approximately 5-10% of older adults meet the diagnostic criteria for an anxiety disorder, with phobic disorders being most prevalent. Generalized anxiety disorder is also seen in older adults, with approximately half of the cases having an onset in late life (Le Roux, Gatz & Wetherell, 2005).

Alcohol/Substance Abuse Disorders: Estimates of alcohol abuse among older adults range from 3-9%, with males being four times more likely than females to experience problems (see Butler, et al. 1998, p. 175). These estimates may be low even at the high end of the range given the “hidden” nature of the problem allowed by a retired lifestyle.

Less than 0.1% of older adults use illicit drugs. Most substance abuse problems among older adults result from improper drug usage (overuse, under use, punctuated use), although prescription drug dependence may develop in older adults, particularly among women.

Barriers

Barriers to receiving mental health services include: (see Aiken, 1995)

- older adults often lack transportation to and from mental health services;
- services that exist are often inadequate (too few services, overloaded services, lack of outreach/advertising to promote awareness of a service, etc.);
- older adults received early socialization during an era that promoted self-sufficiency and often associate mental problems with personal weakness. In addition, treatment alternatives are further discouraged because cognitive problems are often seen by professionals and laypersons as a natural consequence of aging;
- only 50% of older adults in need of mental health care receive treatment from a health care provider, most typically a physician with no specific training in geriatrics. Only 3% of the 50% of older adults who need and receive treatment do so from a mental health specialist;
- system-wide lack of resources results in a lack of coordination across service options
- individuals lack resources and knowledge to access a fragmented service-delivery system.

Solution(s) to overcome barriers:

The solutions must include partnerships of governmental agencies with private entities to provide comprehensive services in a “seamless system of care”.

Some possible solutions to address mental health issues:

- education programs for persons with mental illness and their families;
- education for caregivers;
- education for professionals who have an older adult clientele;
- general education programs to produce an informed public;
- respite care grants to provide relief for caregivers;
- health and wellness initiatives to combat excess morbidity among persons affected by mental illness.

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Faith-Based Organizations and Social Service Programs and Services for Older Adults

By

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Issue: Faith-based organizations and social service programs and services for older adults.

Statement of the issue as addressed in the paper

Faith-based organizations should become more involved in developing social service programs for older adults. In the current political climate, the government is providing fewer social service programs and future prospects are bleak. The literature provides evidence that religion and faith-based organizations are very important in the lives of Americans, particularly the current cohort of ethnically diverse elders. Churches remain untapped resources for the provision of social services and they can fill the gap.

Historically, the church was the sole provider of services for the poor, the elderly, the orphaned, and the needy. In Colonial America, the separation of church and state became the central focus for the Puritans who urged government to take on responsibility for solutions to societal problems. During the Roosevelt administration, the creation of government-sponsored social services became a national priority as evidenced by the passage of the Social Security Act of 1935. The Kennedy and Johnson years continued the federal government's expansion into social service provision with the passage of both the Medicare and Medicaid Acts in 1965, ushering in the Great Society era. The Reagan-Bush administrations introduced a new era of diminishing federal responsibility through devolution. The policy of devolution of social services to the local level contributed to more federal budget cuts for social programs. The end of welfare as it was known in the 1990s found community members with cuts in food stamp programs, Supplemental Social Insurance, Medicaid, and child welfare programs. Communities with dwindling financial resources are being challenged to meet the needs of their older citizens. As policy-makers concede that the federal government cannot meet all needs, President George W. Bush is supporting the efforts of faith-based community initiatives to provide for the unmet and under met needs of communities and introduced in 2001, The Charitable Choice Act. This provision opened the door for states to contract with religious organizations without impairing the religious character of the organization and without diminishing the religious freedom of the beneficiaries of assistance funded under such program.

Furthermore, from primitive to modern times religion is strongly intrinsic in human life; thus the church, synagogue or mosque has a social responsibility to its congregation. As Simmons (1991) states, "if we don't who will" (p.17)? Religion is important to Americans and in particular to older persons. Over 76% of church and synagogue members are over 50 years of age (U.S. Census, 2000). A Gallup poll reported that 71% of Americans claim to be members of a church or synagogue and 41% report having attended church seven days prior to the survey (Cnaan, 1997). According to Tobin, Ellor & Anderson-Ray (1986) three out of four persons 60 years and older report that religion is important in their lives and four out of five persons older than 65 years of age attend church or synagogue regularly .

Religiousness or spirituality, whether described as institutional or personal, correlates positively with better morale, stronger coping skills, and better physical and

mental health. For example, some studies found that depression and alcohol abuse are less prevalent in religious older adults (Zucker, Fair, & Branchey, 1987). Hypertension, anxiety, and cardiac problems are positively influenced by religious behaviors (Krause, 1991). Older people who are religious are happier, have better coping mechanisms, less depression, and better physical and mental health (Johnson, 1995).

The literature also indicates that older persons prefer social services delivered by faith organizations rather than community agencies. Gulledge (1992) describes clergy as the first persons contacted when families are in crisis. In another study, older persons were asked which programs they would be willing to attend at their places of worship. Over 55 percent responded programs relating to emotional health, 24 percent financial programs, 42 percent health programs, 31 percent legal programs, 49 percent programs relating to personal needs, and 50 percent said recreation and educational programs. Over 70 percent of the respondents reported that they would be more willing to attend social service programs in their places of worship than at a community agency (Tirrito & Spencer-Amado, 2000).

In examining the rationale for the church as a service provider, the literature points to the failure of community social service agencies to provide needed services to older adults. Netting, Thibault & Ellor (1988) found evidence that older adults, particularly ethnic older persons, underutilized community social services. Older adults infrequently use community mental health services and consequently, older adults are frequently untreated for depression, dementia, and alcohol and drug abuse.

Barriers to be overcome in order to act on the issue

Cooperation and communication between community agencies and faith-based organizations are essential**.**

Training is needed to address the lack of leadership of clergy and lay leaders in the development of needed programs and services.

A significant barrier for religious and lay leaders is the absence of a method to develop community action programs in faith-based organizations. The Faith Based Community Action Model (FBCAM) was developed for that purpose (Tirrito and Casio, 2003).

Lack of financial resources among faith-based organizations must be addressed.

Issues regarding the separation of church and stated and freedom from religious influence in the provision of services must be clearly articulated and resolved.

Workable solution(s) to overcome barriers

Church leaders, academicians and social activists can be instrumental in providing needed knowledge and leadership. The religious community has the potential to develop partnerships with the neighborhood community, in order to address the needs of elders. While good intentions are critical, knowledge and collaboration are essential .The diversity of the aging population and the variety of churches, synagogues, and mosques in various communities necessitates the need for programs that are unique to each community.

The old ways are no longer suitable. New challenges require new efforts by the church and the government. Thus, the challenge to restructure the formal service system leads one to examine the potential of untapped natural support systems, the thousands of faith organizations (churches, temples, mosques, synagogues) that can fill the gap of need services for the burgeoning population of older adults.

Recommendations for Action

Increased funding to faith-based organizations for social services and programs for older adults and support for the Office of Faith-Based Initiatives to expand its work.

Training for leaders (lay leaders and clergy) in faith- organizations to develop programs and services for older adults.

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Healthcare: Need to Enhance and Encourage Healthy Lifestyles/Disease Prevention—Nutrition and Aging, Physical Activity and Aging

By

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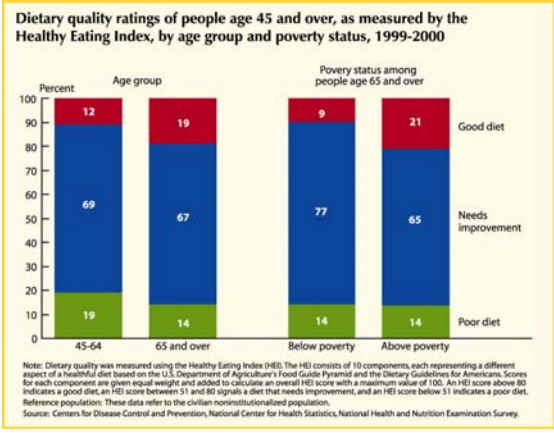
Issue/problem: Healthcare: Need to enhance and encourage healthy lifestyles/disease prevention – Nutrition and Aging, Physical Activity and Aging

The leading causes of death for older Americans are heart disease, cancer, and stroke (respectively). Approximately 45% of persons age 70 or older reported having hypertension, and 21% reported having heart disease. Other chronic diseases included cancer (19%), diabetes (12%), and stroke (9%). The prevalence of chronic conditions varies by race and ethnicity in the older population. Non-Hispanic black persons were more likely to report having diabetes, stroke, and hypertension than either non-Hispanic white persons or Hispanic persons. Cancer was reported by 21% of non-Hispanic white persons, compared with 9% of non-Hispanic black persons, and 11% of Hispanic persons.[1]

Good nutrition and physical activity is essential to the health, independence and quality of life of older adults and are major determinants of successful aging. Dietary quality and physical activity play a major role in preventing or delaying the onset of chronic diseases such as coronary heart disease, certain types of cancer, stroke, and Type 2 diabetes.[2] A healthy diet and regular physical activity can reduce some major risk factors for chronic diseases, such as obesity, high blood pressure, and high blood cholesterol.[3] Physical activity helps to maintain independent living by improving strength, flexibility, mobility, functioning and balance influencing the ability to perform ADL's and IADLs and reducing incidence of falls. [4]



Many older Americans, however, receive sub-optimal nutrition and have a sedentary lifestyle. A majority of older people reported diets that needed improvement (67%) or were poor (14%). Older people living in poverty were less likely to report a good diet (9%) than older people living above the poverty level (21%). Older peoples' scores were lowest for the components of the Healthy Eating Index measuring daily servings of fruit and milk products. [1] Thirty-four percent of persons age 65 or older have a sedentary lifestyle. [4]

Financial Impact

Evidence shows that improving nutrition and increasing physical activity among older adults reduces healthcare costs. The cost of an estimated 30 million people living with cardiovascular disease, diabetes mellitus, kidney disease, hypertension, obesity and osteoporosis – conditions responsive to medical nutrition therapy - is over $300 billion. [6] In 2000, the total cost of overweight and obesity alone was estimated to be $117 billion. [5] The Medicare and Medicaid programs currently spend $84 billion annually on five major chronic conditions that could be significantly improved by increased physical activity, specifically diabetes, heart disease, depression, cancer and arthritis. Medicare spent $10.4 billion on diabetes treatment and services in 2000 and is estimated to spend $12.7 billion in 2004. [5] Physically active people have fewer hospital stays and physician visits and use less medication than physically inactive people. The biggest difference in direct medical costs is among women 55 and older. [5] Adults with poor nutritional status, especially those consuming inadequate food and fluids, are more likely to have serious complications, require institutional or home-based care, and have greater reliance on prescription drugs.[6]

Barriers

About 30 million live with chronic diseases for which nutrition therapies and physical activity can be effective in managing and treating. Meanwhile the vast majority of homebound older adults rely on informal caregivers, most of whom are untrained and unprepared for care management or health promotion.

Although food and nutrition services and physical activity programs are currently provided to older adults through health care, social support systems and senior centers, these services are not universal, or the participation rates are low. For example, while an average of 1.7 million Americans age 60 and older received food stamps, only about a third of older people who are eligible participate in the program.

Solutions

A broad array of culturally appropriate food and nutrition services as well as physical activities and supportive care are vital for maintaining the health of the older adult population and they are needed in the wide variety of settings in which older adults live and receive health care. These include acute, sub acute, skilled nursing, rehabilitation, community health, congregant feeding, home care, adult day care, life care, assisted-living, and nursing facilities.

Public and private initiatives are needed to improve the safety net for nutrition and physical activity among the nation's older adults. Government, academia, the health care community, civic and religious institutions and individuals all have roles to play in assuring that older adults' nutritional and physical activity needs are met. Support and coordination of activities and partnerships are vital if improvements are to be made and sustained.

Support the employment of registered dietitians, who are uniquely qualified to work with older adults, promoting health and functionality to maintain quality of life among the healthy, as well as provide nutrition education for disease management that lessens chronic diseases risk, slows disease progression, and reduces symptoms. Support the employment of certified exercise specialists who have special training in gerontology and the employment of certified health education specialists who are experts in health promotion and health behavior change.

Enhance and support the USDA Food Stamp Nutrition Education Program (FSNE) in targeting older adults with limited resources. FSNE provides educational programs that increase, within a limited budget, the likelihood of food stamp recipients making healthy food choices and choosing active lifestyles consistent with the most recent advice reflected in the Dietary Guidelines for Americans and the Food Guide Pyramid. This national program fosters collaboration and coordination between federal, state and local agencies.

Recommendations

Expansion and funding of federal and state nutrition and physical activity services in home and community-based programs, such as the Older Americans Act Nutrition Program, Food Stamp Nutrition Education (which includes physical activity), and caregiver support programs.

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Oral Health Care Isues

By

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Issue Paper - Research
Oral Health Care Issues

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Statement of the Issue

The terms oral health and general health should not be considered separately. Oral health is important to general health and means more than healthy teeth--you cannot be healthy without oral health. Research is pointing to associations between chronic oral infections and heart and lung diseases, and stroke. Associations between periodontal disease and diabetes have long been noted. For example, infections in the mouth can enter the blood stream and cause serious problems to major organs such as inflammation of the heart valve. The percent of individuals with moderate to severe periodontal disease increases with age. Also, many older persons take multiple medications and at least one will have an oral side effect, dry mouth, which is a risk for oral disease. These diseases and problems can be controlled and prevented through conscientious oral hygiene and oral assessment.[1]

However, there are few dentists across the nation and in South Carolina who are trained in geriatric oral health. Older patients with complex medical conditions are not always given appropriate dental care because dentists and other providers do not feel adequately prepared to care for them. The acute shortage of dentists nationwide is expected to worsen in coming years as dental schools graduate fewer students and many dentists are nearing retirement age. Additionally, it can be predicted that the combination of increasing levels of dental school indebtedness and fee disparities between urban and rural areas will lead to a reduced percentage of dental school graduates locating in rural communities. Culturally relevant geriatric content in dental curricula is needed because of the under representation of minorities in the dental profession.[2,3]

The dental health care of older adults residing in long-term-care (LTC) facilities, especially skilled nursing homes, is problematic.[1] In the LTC setting, there is a lack of time, supervision, and skills of staff to provide oral care for their residents. There are no medical or dental personnel in nursing homes to regularly provide for residents' oral care. Older adults' oral health can be compromised by their inability to care for themselves. Many cannot raise their arms to perform oral hygiene and many are not cognitively aware to take care of their dental needs. This lack of attention to dental needs, including the cleaning of teeth and gums daily, replacement of broken and deteriorating teeth affects a person's ability to eat proper and nutritious foods and can result in malnutrition and even death.

Comparisons of SC with national data on several oral indicators:

- Persons 65+ with a loss of 6 or more teeth due to gum disease is 65.6% for SC as compared to 61.9% for the nation[4]
- Complete tooth loss is 30.2 for SC and 24.4% nationally[5]
- SC is rated 2nd in the nation in oral cancer mortality[6]
- Nationally, oral cancers are primarily diagnosed in the elderly and detection and diagnosis is often delayed with a poor prognosis. The 5-year survival rate for white patients is 56 percent; for blacks, it is only 34 percent.[7]

The Standards for Dental Services for Licensing Nursing Home include the following:

(a) When a person is admitted to a nursing home, an oral assessment by a physician, dentist or registered nurse shall be conducted within two weeks to determine the consistency of diet which the resident can best manage and the condition of gums and teeth. A written report of this assessment shall be placed in the medical record.

(b) Each nursing home shall maintain names of dentists who can render emergency and other dental treatments. Residents shall be encouraged to utilize dental services of choice.

(c) Residents shall be assisted as necessary with daily dental care.[8]

The Healthy People 2010 Objectives[9] include Objectives related to oral health in older adults are

- Increase the proportion of adults who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancers.
- Increase the proportion of long-term care residents who use the oral health care system each year.
- Increase the proportion of persons with diabetes who have at least an annual dental examination.
- Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.
- Increase the proportion of primary care providers, pharmacists, and other health care professionals who routinely review with their patients aged 65 years and older and patients with chronic illnesses or disabilities all new prescribed and over-the-counter medicines.

Barriers to Overcome

- Lack of knowledge among older adults concerning the relationship between oral health and general overall health.
- Lack of public dental insurance -- Medicare does not provide dental benefits.

- Lack of adequate transportation to oral health services in rural areas.
- Poverty and a lack of out-of-pocket funds to pay for oral health care.
- Acute shortage of dentists nationwide with an expectation to worsen in coming years as dental schools graduate fewer students; also many dentists are nearing retirement age.
- Lack of adequate daily dental hygiene care in LTC settings.

Possible Solutions

- Education of faculty, practicing professionals, students, caregivers, and the public about the oral health- general health connection. (In 1993, the South Carolina Geriatric Education Center (SC-GEC) received funds from the USDHHS, HRSA, to develop a 40-hour geriatric oral health curriculum for practicing professionals. One special initiative includes a 2-hour oral, head, and neck skills assessment training for primary care providers to enable them to perform an oral assessment as part of the routine physical examination).
- Inclusion of the older adult in the SC Oral Health Plan (SC-GEC has partnered with SC DHEC, Office on Oral Health, to develop a state oral health plan to include older adults; previously, only children were addressed in the State Plan).
- Development and dissemination of a train-the-trainer program for oral health consultants in LTC settings (SC Oral Health Coalition and the SC-GEC). Consultants would arrange for care, perform regular preventive sessions including how to brush teeth and eat properly, conduct periodic screenings of residents as a preventive measure, provide consultation as to dietary requirements for residents from an oral health perspective, and arrange for mobile dental van visits, and transportation to the dentist.
- Heighten awareness of legislators to the fact that lack of good oral hygiene is preventable and that proper dental hygiene--brushing, flossing, and regular dental checkups can save our nation millions of dollars in health care costs.
- Funding scholarships for practicing dentists and dental hygienists to complete fellowships in geriatric oral health care.
- Creation and distribution of health promotion messages for the public on the oral health-general health connection and on identified health risk factors known to affect oral health such as tobacco and alcohol use and poor dietary practices.
- Make Dental Medicine and Dental Hygiene faculty and students aware of the National Health Service Corps' scholarships and loan repayment to dentists and dental hygienists willing to practice in underserved Dental Health Professional Shortage Areas (see attached SC Dental Shortage Areas Map and employed dentists and dental hygienists in SC).[10,11]

Recommendations for Action

- Conduct a comprehensive study of the role and utilization of dental hygienists, the state practice act to explore their expanded use especially in LTC settings.

- ***Legislate for Medicare reimbursement for dental care for adults 65 and older.***
- Expand Medicaid coverage as a mandatory service for oral health services to eligible adults, including the elderly in long-term care settings and the disabled with special needs.
- Mandate that family practitioners and mid-level providers have training in performing an oral health assessment with the routine physical examination.
- Provide funding for “Best Practices in Oral Health Care” in long-term care settings for adaptation and replication.

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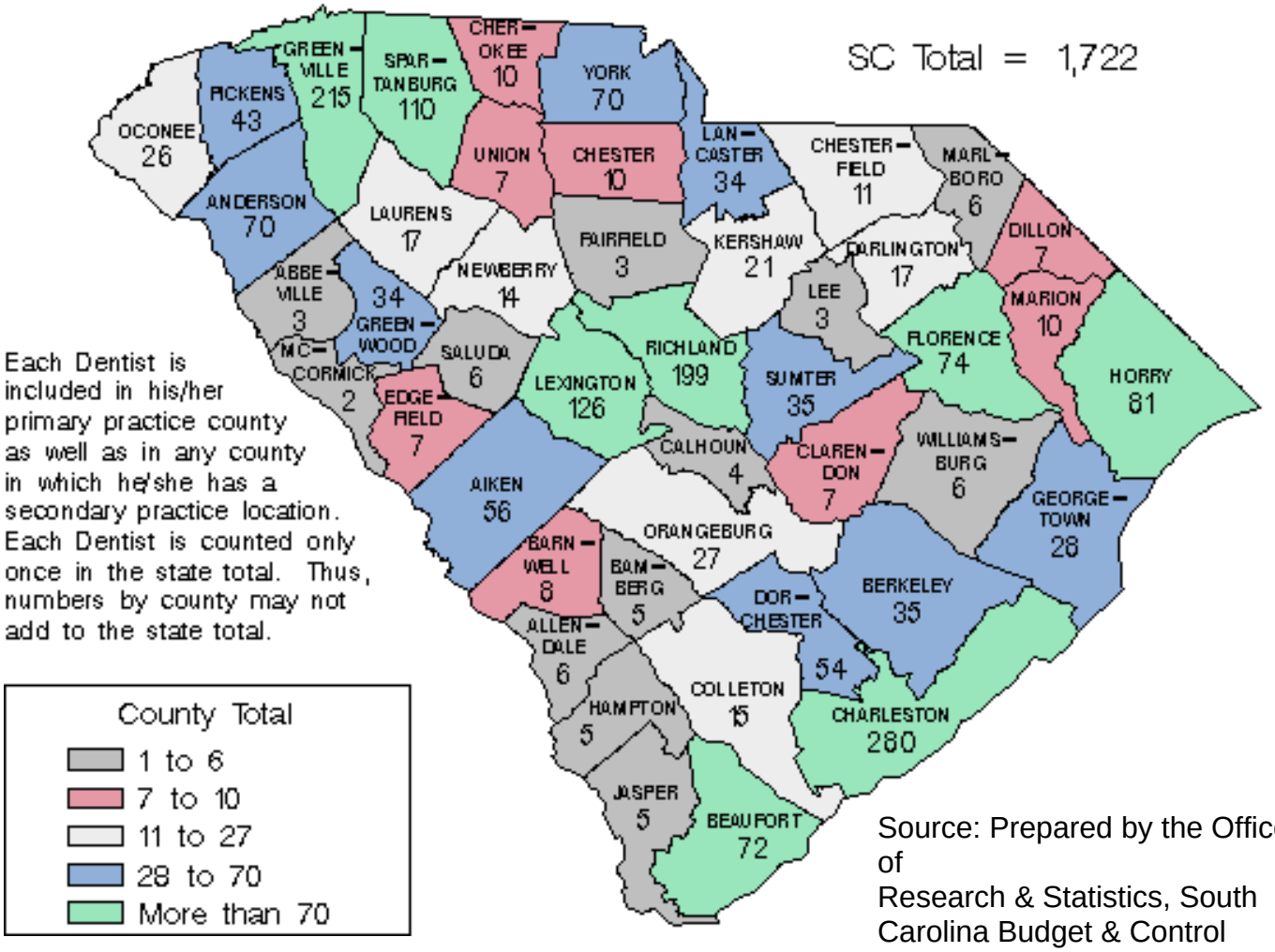
Dentists Employed in South Carolina, 2003

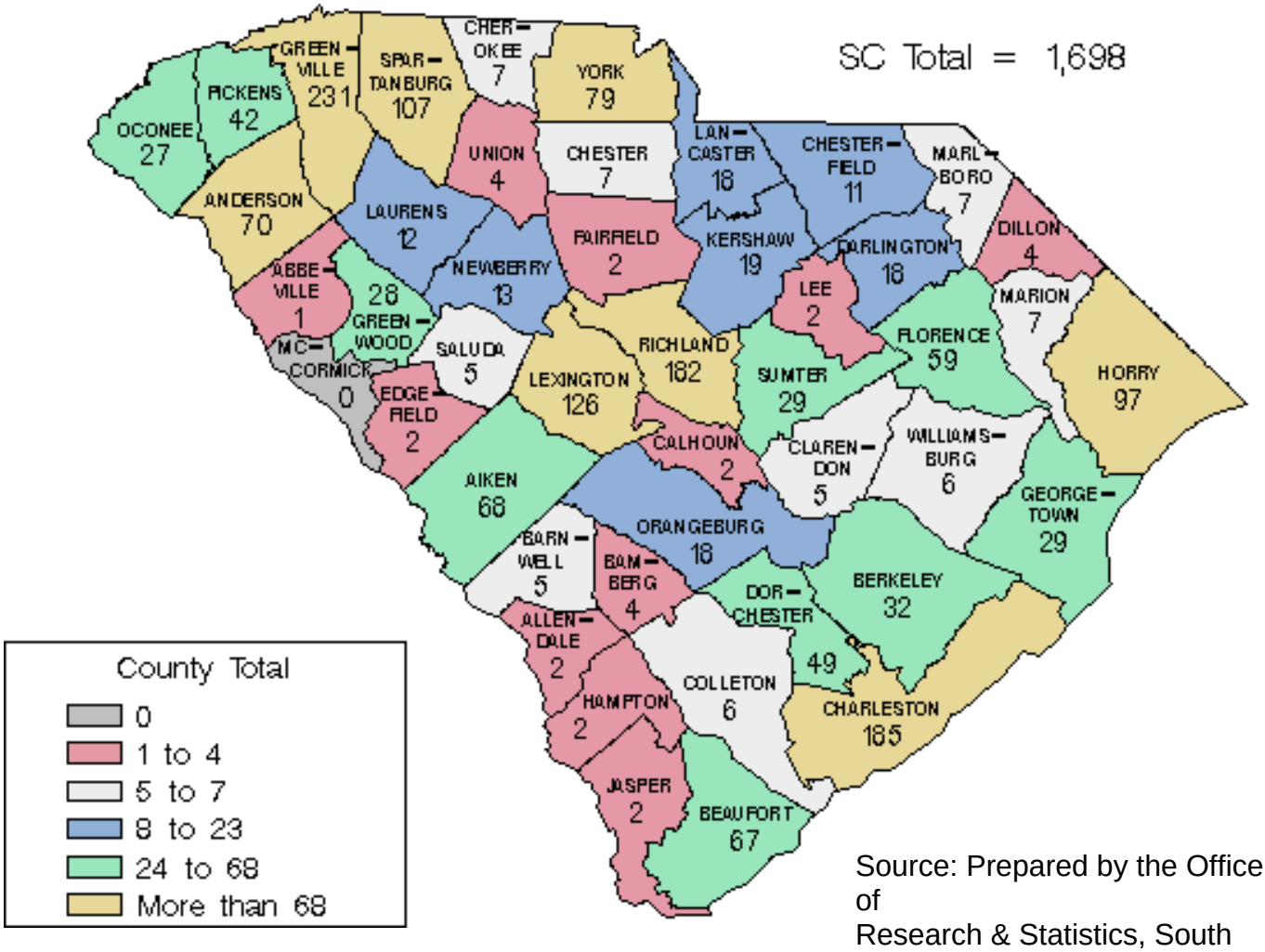


Each Dentist is included in his/her primary practice county as well as in any county in which he/she has a secondary practice location. Each Dentist is counted only once in the state total. Thus, numbers by county may not add to the state total.

County Total
- 1 to 6
- 7 to 10
- 11 to 27
- 28 to 70
- More than 70

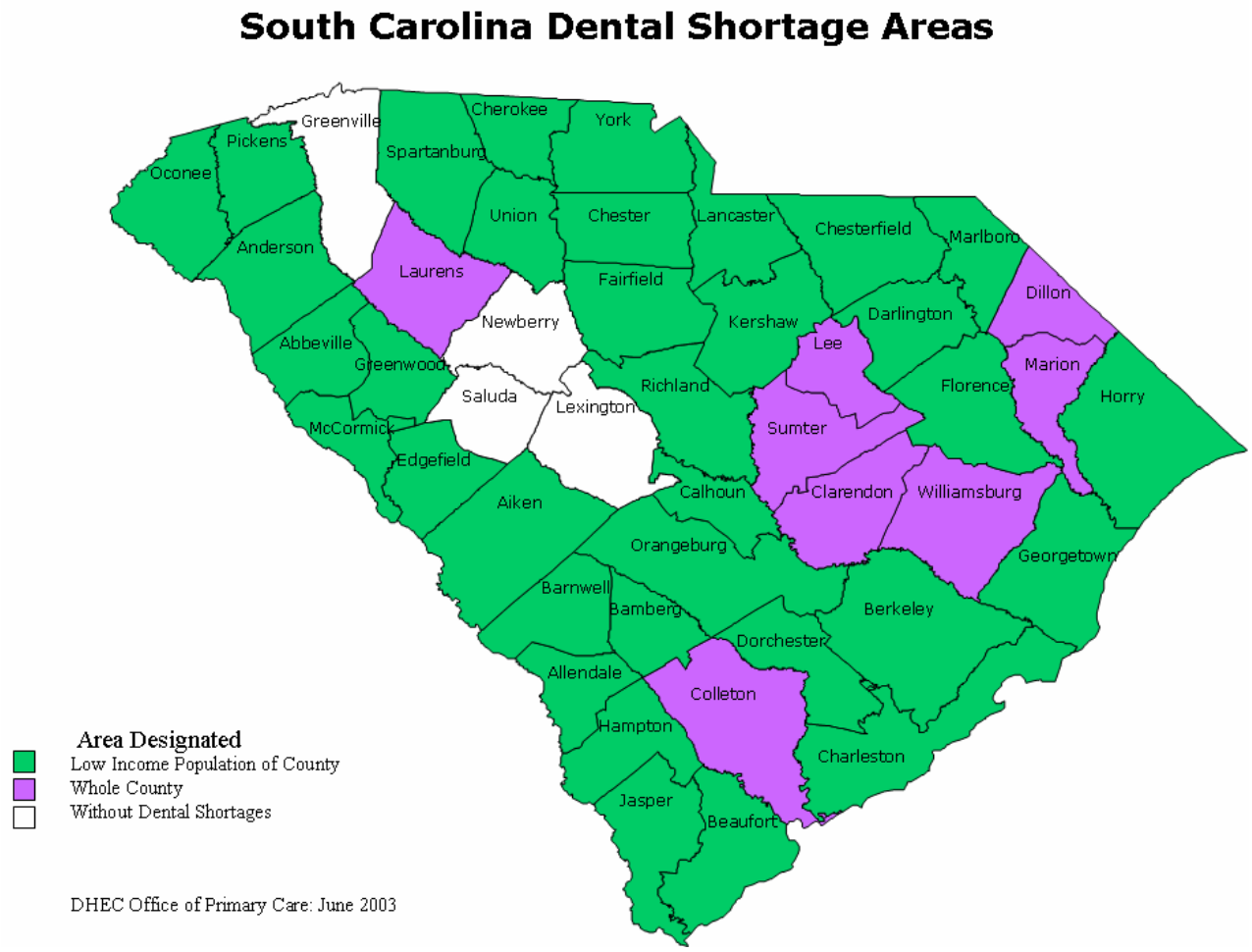
Source: Prepared by the Office of
Research & Statistics, South Carolina Budget & Control

Dental Hygienists Employed in South Carolina, 2003



Source: Prepared by the Office of
Research & Statistics, South Carolina Budget & Control

South Carolina Dental Shortage Areas



SOUTH CAROLINA
DENTAL SHORTAGE AREAS

COUNTY	AREA DESIGNATED
Abbeville County	Low Income Population of County
Aiken County	Low Income Population of County
Allendale County	Low Income Population of County
Anderson County	Low Income Population of County
Bamberg County	Low Income Population of County
Barnwell County	Low Income Population of County
Beaufort County	Low Income Population of County
Berkeley County	Low Income Population of County
Calhoun County	Low Income Population of County
Charleston County	Low Income Population of County
Cherokee County	Low Income Population of County
Chester County	Low Income Population of County
Chesterfield County	Low Income Population of County
Clarendon County	Whole County
Colleton County	Whole County
Darlington County	Low Income Population of County
Dillon County	Whole County
Dorchester County	Low Income Population of County
Edgefield County	Low Income Population of County
Fairfield County	Low Income Population of County
Florence County	Low Income Population of County
Georgetown County	Low Income Population of County
Greenwood County	Low Income Population of County
Hampton County	Low Income Population of County
Horry County	Low Income Population of County
Jasper County	Low Income Population of County Ridgeland Correctional Institution
Kershaw County	Low Income Population of County
Lancaster County	Low Income Population of County
Laurens County	Whole County
Lee County	Whole County
Marion County	Whole County
Marlboro County	Low Income Population of County
McCormick County	Low Income Population of County
Oconee County	Low Income Population of County
Orangeburg County	Low Income Population of County
Pickens County	Low Income Population of County
Richland County	Low Income Population City of Columbia
Spartanburg County	Low Income Population of County
Sumter County	Whole County
Union County	Low Income Population of County
Williamsburg County	Whole County
York County	Low Income Population of County

DHEC Office of Primary Care: June 2003

Community Forums Report

(H)
Research

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

RESEARCH

LOCATION OF EVENT: Capital Senior Center – Columbia, SC

Priority Issue:
Lack of funding for specific chronic diseases as well as healthy aging issues; lack of evidence – focused research and the need for improved linkage between research and practice; general lack of funding to support aging research.

Barriers:
1) The cost of sensitive nature of researching issues.
2) Ageism.
3) The lack of knowledge to translate research into public policy.
4) Definition of quality of life as distinct from a definition of quality of care.
5) Institutional barriers to studying the aging population, such as dementia, nursing home, hospice, etc. Academia is often encouraged to do research in other areas because support is provided in the other areas and not in this one.

Proposed Solution(s):
1) Target funding to programs based on evidence based research.
2) Funders should require researchers to identify practical applications of their research.
3) Funders should require researchers to include community collaboration in identifying issues, setting priorities for research, and implementation of programs.

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
Alzheimer's research, arthritis research, and women's health research.

Barriers:
Recognizing the need for research; governmental regulations.

Proposed Solution(s):
Allocate research funds for senior issues – relax government regulations.

LOCATION OF EVENT: City Council Chambers – Rock Hill, SC

Priority Issue:
Understanding the issues facing seniors is important to identifying possible solutions.

Barriers:
1) What are we doing to change our homes to accommodate seniors.
2) Difficult to change the mindset of people but it is important to do so

Proposed Solution(s):
1) Need to build more accessible housing for elderly.
2) Need to do more to educate doctors about the needs of seniors.
3) New program in South Carolina to train doctors for specializing in geriatrics.